

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: R: This certificate should be executed within 24 hours after death. If necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MEDICAL CERTIFICATION

08291										DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										08284																			
1. DECEASED-NAME (Type or Print) B First <u>Gerald</u> Middle <u>E.</u> Last <u>Bedford</u>										2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> Month <u>6</u> Day <u>27</u> Year <u>1969</u>										2b. HOUR <u>11-45</u>																			
3. SEX <u>Male</u>			4. RACE <u>W-US</u>			5. DATE OF BIRTH <u>12-21-42</u>			6. AGE (In years last birthday) <u>26</u> YRS.			IF UNDER 1 YEAR MONTHS <u>0</u> DAYS <u>0</u>			IF UNDER 24 HRS. HOURS <u>0</u> MIN. <u>0</u>			2c. DATE PRONOUNCED DEAD <u>6-27-69</u> Day <u>19</u> Year <u>19</u>										2d. HOUR <u>11-45</u>											
7a. BIRTHPLACE (State or foreign country) <u>California</u>					7b. CITIZEN OF WHAT COUNTRY? <u>USA</u>					8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>					9. COUNTY OF DEATH <u>Charles County Md.</u>										Md.														
10. CITY OR TOWN OF DEATH <u>Bryans Road Md.</u>										11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <u>US-Army</u>										12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <u>US-Army</u>										12b. KIND OF BUSINESS OR INDUSTRY <u>US-Army</u>									
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <u>Ala.</u>										13b. COUNTY <u>Ft. Mc Clellan</u>										13c. CITY OR TOWN <u>3634 B Morton Rd.</u>										13d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO									
14. FATHER'S NAME First <u>Hugh R.</u> Middle <u>Bedford</u> Last <u></u>										15. MOTHER'S MAIDEN NAME First <u>Janice M.</u> Middle <u>Jones</u> Last <u></u>																													
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u>										16b. SOCIAL SECURITY NO. <u>460 70 3309</u>										17. INFORMANT <u>Barbara D. Bedford</u>										ADDRESS <u>See 13 a c e</u>									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE <u>Injuries Multiple</u> DUE TO, OR AS A CONSEQUENCE OF <u>Airplane Crash</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <u>841.1</u> (b) <u></u> DUE TO, OR AS A CONSEQUENCE OF <u></u> (c) <u></u>										Extreme										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>Immediate</u>																			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)																																							
19a. DATE OF OPERATION										19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?										20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>																			
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH										21b. TIME OF INJURY Month, Day, Year <u>10-30 AM</u> <u>19</u> P.M. <u></u>										21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) <u>Airplane crash</u>																			
21d. INJURY OCCURRED WHILE AT WORK <input checked="" type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>										21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)										21f. LOCATION Street or R.F.D. No. <u>Bryans Road</u> City or Town <u>Charles</u> County <u>Md.</u> State <u></u>																			
22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion																																							
ACTUAL SIGNATURE <u>James E. Andrews MD</u>										CHIEF MEDICAL EXAMINER <input type="checkbox"/>										22b. DATE SIGNED <u>6-27-69</u>																			
EXAMINER'S NAME (Type)										ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>																													
										DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>																													
										ADDRESS (Street, city, town, or county)																													
23a. BURIAL/CREMATION, REMOVAL (Specify) <u>Burial</u>										23b. DATE <u>6-30-1969</u>										23c. NAME OF CEMETERY OR CREMATORY <u>Jacksonville, Florida</u>										23d. LOCATION (City or Town) (County) (State)									
24. FUNERAL DIRECTOR <u>W.W. Chambers Co.</u>										1400 Chain St. NW Washington, D.C.										25a. REC'D BY REGISTRAR <u>JUL 2 1969</u>										25b. REGISTRAR'S SIGNATURE <u></u>									

U. S. DEPARTMENT OF AGRICULTURE

1917-18

1917-18

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
08292					08285				
CERTIFICATE OF DEATH									
1. DECEASED-NAME (Type or print)			First	Middle	Lost	2a. DATE OF DEATH			2b. HOUR
Willson Charles Bowling Sr.						June 22 Day 1969			M
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR	
Male		Cauc		Jan. 11, 1893		76 YRS.		MONTHS DAYS HOURS MIN	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH		Md.	
Maryland		USA				Charles			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY			
La Plata		/		Merchant -Dept. Store					
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER	
Maryland		Charles		La Plata				Hawthorne Drive	
14. FATHER'S NAME			First	Middle	Lost	15. MOTHER'S MAIDEN NAME			First Middle Lost
Philip Simms Bowling						Mary Louise Stuart			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes (no, or unknown)		16b. SOCIAL SECURITY NO.		17. INFORMANT		Address			
Yes		WW 1		218-16-0226		Mr. James A. Mudd -Son-in-law-La Plata			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4123 Arteriosclerosis heart Disease								5 yrs.	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.									
DUE TO, OR AS A CONSEQUENCE OF (b)									
DUE TO, OR AS A CONSEQUENCE OF (c)									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
Anemia									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
		HOUR A.M. Month Day Year P.M. 19							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION		Street or R.F.D. No.		City or Town County State	
22a. I certify that (I) (this hospital) attended the deceased from 6/22, 1969, to 6/22, 1969, that (I) (we) last saw the deceased alive on 6/22, 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE		DEGREE		ATTENDING PHYS.		MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED	
Arturo M. Monteiro								6/23/69.	
22d. PHYSICIAN'S NAME (Type)		22e. ADDRESS		22f. ADDRESS					
Arturo M. Monteiro		La Plata, Md.		La Plata, Md. 20646					
23a. BURIAL, CREMATION, or other disposition (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)			
Burial		6/28/ 1969		St. Ignatius Cemetery		Chapel Point, Md.			
24. FUNERAL DIRECTOR				ADDRESS		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
Arehart Funeral Home, Inc.-La Plata, Md.						JUN 30 1969		James Judge	

Division of General Services, Washington, D.C.

Date: June 11, 1959

Subject: General Services Administration

Reference: GSA - 100-100000

Re: General Services Administration

Enclosed for the General Services Administration

is one copy of the report of the General Services Administration

dated June 11, 1959.

Very truly yours,

Director, General Services Administration

Enclosure

cc - General Services Administration

cc - General Services Administration

cc - General Services Administration

cc - General Services Administration

cc - General Services Administration

cc - General Services Administration

cc - General Services Administration

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
08293		MEDICAL EXAMINER'S CERTIFICATE OF DEATH						08286	
1. DECEASED-NAME (Type or Print)		First Middle Last W.R. Bryan- Capt-USA William R. Bryan				2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> Month Day Year 6-27-69 19		2b. HOUR 11-45 AM	
3. SEX Male	4. RACE W-US	5. DATE OF BIRTH 8-24-43	6. AGE (In years last birthday) 25 YRS	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN		2c. DATE PRONOUNCED DEAD Month 6 Day 27 Year 69		2d. HOUR 1145 AM	
7a. BIRTHPLACE (State or foreign country) Louisiana		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Charles County Md.			
10. CITY OR TOWN OF DEATH Charles Co., Md.		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Beauregard De Ridder				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Officer		12b. KIND OF BUSINESS OR INDUSTRY U.S. Army	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE La.		13b. COUNTY Beauregard		13c. CITY OR TOWN De Ridder		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER Glendale Rd.	
14. FATHER'S NAME First Middle Last Robert Bryan				15. MOTHER'S MAIDEN NAME First Middle Last Blanche Cammack					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes		16b. SOCIAL SECURITY NO. (If yes give way or dates of service) Active 435 60 7915		17. INFORMANT Glendale Rd. Robert Bryan De Ridder, Louisiana					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Injuries Multiple Eextreme Plzne Accident</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Airplane Crash</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Immediate									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY Month Day Year 10-30 AM 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) Airplane Crash					
21d. INJURY OCCURRED WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) Charles County Md.		21f. LOCATION Street or R.D. No. City or Town County State Bryans Road Md.					
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE EXAMINER'S NAME (Type) James E. Andrews MD				CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> ADDRESS (Street, city, town, or county)				22b. DATE SIGNED 6-27-69	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 7-2-69		23c. NAME OF CEMETERY OR CREMATORY Beauregard Cemetery		23d. LOCATION (City or Town) (County) (State) De Ridder, Beauregard, La			
24. FUNERAL DIRECTOR W.W. Chambers Co.				25a. REC'D BY REGISTRAR JUL 2 1969		25b. REGISTRAR'S SIGNATURE Charles Judge			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. at Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

08294										DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										08287									
1. DECEASED-NAME										2a. DATE OF DEATH										2b. HOUR									
First Middle Last										Month Day Year										M									
Rudolf Ambrose Carrico										June 9 1969																			
3. SEX			4. RACE			5. DATE OF BIRTH			6. AGE (In years last birthday)			IF UNDER 1 YEAR MONTHS			IF UNDER 24 HRS. DAYS			IF UNDER 24 HRS. HOURS			IF UNDER 24 HRS. MIN.								
Male			Cauc.			Feb. 26, 1908			61																				
7a. BIRTHPLACE (State or foreign country)					7b. CITIZEN OF WHAT COUNTRY?					8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>					9. COUNTY OF DEATH														
Maryland					USA										Charles														
10. CITY OR TOWN OF DEATH					11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)					12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)					12b. KIND OF BUSINESS OR INDUSTRY														
Bryantown										Attorney					Law														
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE					13b. COUNTY					13c. CITY OR TOWN					13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					13e. STREET AND NUMBER									
Maryland					Charles					Bryantown																			
14. FATHER'S NAME First Middle Last					15. MOTHER'S MAIDEN NAME First Middle Last																								
Louis C. Carrico					Annie Jameson																								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown (If yes give war or dates of service)					16b. SOCIAL SECURITY NO.					17. INFORMANT Address																			
Yes					217-36-7218					Eleanor May Carrico, Bryantown, Md.																			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH																			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4109 Coronary Occlusion										6-9-69																			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Sen. ant. fee										1955																			
DUE TO, OR AS A CONSEQUENCE OF (c)																													
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)																													
19a. DATE OF OPERATION					19b. CONDITION FOR WHICH OPERATION WAS PERFORMED					20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?														
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)					21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19					21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)																			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>					21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)					21f. LOCATION Street or R.F.D. No. City or Town County State																			
22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.																													
22b. SIGNATURE <i>E. J. Edelen</i> DEGREE										ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>					22c. DATE SIGNED														
22d. PHYSICIAN'S NAME (Type) E. J. Edelen M.D.										22e. ADDRESS La Plata, Maryland 20646																			
23a. BURIAL, CREMATION, REMOVAL (Specify)					23b. DATE					23c. NAME OF CEMETERY OR CREMATORY					23d. LOCATION (City or Town) (County) (State)														
Burial					June 11, 1969					St. Mary's					Bryantown, Charles, Md.														
24. FUNERAL DIRECTOR ADDRESS										25a. REC'D BY REGISTRAR DATE					25b. REGISTRAR'S SIGNATURE														
Arehart Funeral Home Inc., La Plata, Md.										JUN 17 1969					<i>Charles Judge</i>														

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VR A15
45M - 1/55

08295		DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201				CERTIFICATE OF DEATH		08288	
1. DECEASED-NAME (Type or print)		First	Middle	Last	2a. DATE OF DEATH		2b. HOUR		
MINNIE ANN CHASE					Month Day Year JUNE 19 1969		M		
3. SEX	4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR		
F	C		2-19-1878		91 YRS.		MONTHS DAYS HOURS MIN		
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			
MARYLAND		United State				Charles Md.			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY			
LA PLATA		Physicians		HOUSEWIFE					
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER	
MARYLAND		Charles		Waldorf				Route 1 Box 254C	
14. FATHER'S NAME		First	Middle	Last	15. MOTHER'S MAIDEN NAME		First	Middle	Last
George				HAWKINS	Margaret				Green
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown		16b. SOCIAL SECURITY NO.		17. INFORMANT		Address			
No		NONE							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY:									
IMMEDIATE CAUSE (a) acute cardiac dilatation								2 hrs.	
4409 DUE TO, OR AS A CONSEQUENCE OF									
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) atherosclerosis								10 years	
DUE TO, OR AS A CONSEQUENCE OF (c)									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (c)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from 6-16, 1969, to 6-19, 1969, that (I) (we) last saw the deceased alive on 6-19, 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE F. M. Johnson				DEGREE ATTENDING PHYS. MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 6-20-69			
22d. PHYSICIAN'S NAME (Type) F. M. JOHNSON M.D.				22e. ADDRESS LA PLATA, Md.					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE 6/23/69		23c. NAME OF CEMETERY OR CREMATORY St. Joseph's		23d. LOCATION (City or Town) (County) (State) Baltimore Md.			
24. FUNERAL DIRECTOR Heroy		24b. ADDRESS 2224 Parkway		25a. REC'D BY REGISTRAR JUN 30 1969		25b. REGISTRAR'S SIGNATURE Charles Judge			

1920

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove coroner papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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08296

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

08289

1. DECEASED-NAME (Type or print) <u>Baby</u> <u>Girl</u>		Last <u>Gates</u>		2a. DATE OF DEATH Month <u>June</u> Day <u>3</u> Year <u>1969</u>		2b. HOUR <u>6:15</u> M	
3. SEX <u>Female</u>		4. RACE <u>White</u>		5. DATE OF BIRTH <u>June 3, 1969</u>		6. AGE (In years lost birthday) <u>YRS</u>	
7a. BIRTHPLACE (State or foreign country) <u>Maryland</u>		7b. CITIZEN OF WHAT COUNTRY? <u>United States</u>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <u>Charles</u> Md.	
10. CITY OR TOWN OF DEATH <u>LaPlata</u>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <u>Physicians Mem. Hosp.</u>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <u>Infant</u>		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE <u>Md.</u>		13b. COUNTY <u>Charles</u>		13c. CITY OR TOWN <u>Potomac Heights</u>		13d. INSIDE CITY LIMITS? <input type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME First <u>Raymond</u> Middle <u>Gates</u> Last <u>Gates</u>		15. MOTHER'S MAIDEN NAME First <u>Louise</u> Middle <u>Morton</u> Last <u>Morton</u>		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, <input type="checkbox"/> No, <input checked="" type="checkbox"/> (If yes give war or dates of service)			
16b. SOCIAL SECURITY NO <u>None</u>		17. INFORMANT Address <u>Raymond Gates - Potomac Heights, Md.</u>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Respiratory Collapse -</u> <u>7762</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>2 hrs.</u>
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. _____ Month _____ Day _____ Year _____ P.M. _____		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work _____ of work _____		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY) _____ (OFFICE BUILDING, ETC.) _____		21f. LOCATION Street or R.F.D. No _____ City or Town _____ County _____ State _____			
22a. I certify that (I) (this hospital) attended the deceased from <u>3 June, 1969</u> , to <u>3 June, 1969</u> , that (I) (we) last saw the deceased alive on <u>3 June, 1969</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <u>Arthur O. Wooddy</u>		DEGREE <u>MD</u>		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <u>4 June 1969</u>	
22d. PHYSICIAN'S NAME (Type) <u>Arthur O. Wooddy</u>		22e. ADDRESS <u>La Plata, Maryland</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE <u>6/5/69</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Trinity Mem. Gardens</u>		23d. LOCATION (City or Town) (County) (State) <u>Waldorf, Md.</u>	
24. FUNERAL DIRECTOR <u>Arehart Funeral Home, Inc. - La Plata, Md.</u>		ADDRESS		25a. REC'D BY REGISTRAR <u>JUN 9 1969</u>		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>	

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

08297

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08290

1. DECEASED NAME (Type or Print)		First	Middle	Last	2a. DATE KNOWN OF DEATH		<input type="checkbox"/> Month <input type="checkbox"/> Day <input type="checkbox"/> Year	2b. HOUR
PINKNEY		J.		HAWKINS	June 7, 1969			12:30A
3 SEX	4 RACE	5 DATE OF BIRTH	6. AGE (In years lost birthday)	7. UNDER YEAR	8. IF UNDER 24 HRS		2c. DATE PRONOUNCED DEAD	
Male	Negro	May 14, 1929	40 YRS	MONTHS	DAYS	HOURS	MIN.	2d. HOUR
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH		
Char. Co. Md.		U.S.A.				Charles		MD
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY		
LaPlata		Physicians Memorial Hospital						
13a. USUAL RESIDENCE (Where deceased lived, if institution admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY, APTS?		13e. STREET AND NUMBER
Maryland		Charles		Hughesville		YES <input type="checkbox"/> NO <input type="checkbox"/>		
14. FATHER'S NAME		First	Middle	Last	15. MOTHER'S MAIDEN NAME		First	Middle
James A. Hawkins					Mary A. Lyles			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS		
				Ruth C. Bell		Box 73 Bryantown, Md.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Fatty Metamorphosis of Liver</u>								
5718 DUE TO, OR AS A CONSEQUENCE OF								
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost								
(b) DUE TO, OR AS A CONSEQUENCE OF								
(c)								
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)								
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY?
								YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/>		21b. TIME OF INJURY Month, Day, Year		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)				
CAUSE OF DEATH		HOUR A.M. P.M.						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No		City or Town		County
								State
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>								
ACTUAL SIGNATURE		Russell S. Fisher		M.D.		CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/>		22b. DATE SIGNED
EXAMINER'S NAME (Type)		Russell S. Fisher, M.D.				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		6/8/69
						DEPUTY MEDICAL EXAMINER <input type="checkbox"/>		
						ADDRESS (Street, city, town, or county)		
23a. BURIAL CREMATION REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town)		(County) (State)
Burial		June 12/69		St. Mary Church Cem.		Bryantown Ch. Co. Md.		
24. FUNERAL DIRECTOR		ADDRESS		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE		
Martell Adams		Aguasco, Md.		JUL 17 1969		J. Charles Jones		



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, all in any event, within 72 hours after death.

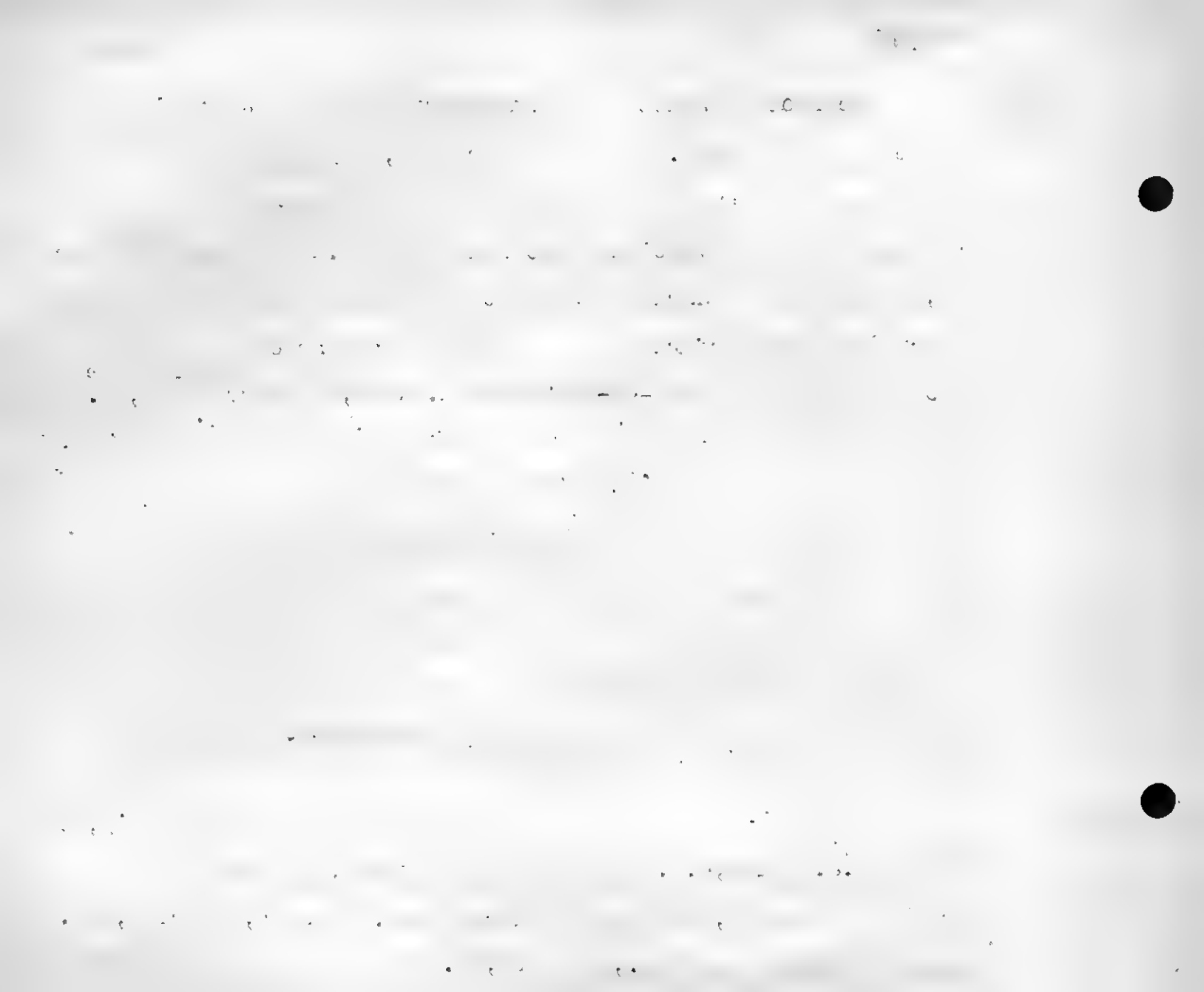
08298

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

08291

1 DECEASED-NAME (Type or print)		First	Middle	Last	2a. DATE OF DEATH Month Day Year		2b HOUR		
Reginald Price				Hungerford	June 12 1969		M		
3 SEX	4 RACE		5. DATE OF BIRTH		6. AGE (In years lost birthday)		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN		
Male	Cauc.		April 30, 1885		84 YRS.				
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			
Maryland		USA				Charles			
10 CITY OR TOWN OF DEATH		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY			
La Plata		Physicians Memorial		Ret. Accountant		US Govern			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER	
Maryland		Charles		La Plata					
14 FATHER'S NAME First Middle Last				15 MOTHER'S MAIDEN NAME First Middle Last					
John Gwinn Hungerford				Mary Susan Price					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown (If yes, give war or dates of service)		16b. SOCIAL SECURITY NO.		17 INFORMANT					
No		216-46-0649		8403 Cathedral Ave Mary H. Baden, New Carrollton, Md.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Vascular Accident 6-10-69</u> 4 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerosis</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Hypertension</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1967 6-69									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from 1967, 19, to 6-12-69, that (I) (we) last saw the deceased alive on 6-12-69, and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE		DEGREE		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED			
22d. PHYSICIAN'S NAME (Type)		22e. ADDRESS		June 13, 1969					
E.J. Edelen, M.D.		La Plata, Maryland							
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)			
Burial		June 14, 1969		Christ Church Ceme.		Wayside, Charles, Md.			
24. FUNERAL DIRECTOR ADDRESS				25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
Arehart Funeral Home Inc., La Plata, Md.				JUN 17 1969		Charles Judge			



FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word 'pending' in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form 8M-2. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal and in any event within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										
<div>08299</div> <div>MEDICAL EXAMINER'S CERTIFICATE OF DEATH</div> <div>08292</div>										
1. DECEASED NAME (Type or Print)		First		Middle		Last		2a. DATE KNOWN OF DEATH		2b. HOUR
JAMES EDWARD		JENIFER						<input checked="" type="checkbox"/> Month <u>7</u> Day <u>1</u> Year <u>1969</u>		<input checked="" type="checkbox"/> 5P M
3 SEX	4 RACE	5 DATE OF BIRTH	6 AGE (in years last birthday)	IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN		2c. DATE PRONOUNCED DEAD		2d. HOUR
Male	Negro	11/25/1950	18 YRS					<input checked="" type="checkbox"/> Month <u>7</u> Day <u>1</u> Year <u>1969</u>		<input checked="" type="checkbox"/> 4P M
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH				2e. KIND OF BUSINESS OR INDUSTRY
Maryland		U.S.A.				Charles				Farming
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY				
Marshall Hall		Potomac River		Farm Hand		Farming				
13a. USUAL RESIDENCE (Where deceased lived, if institution - Res. since before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER		
Md.		Charles		Pomfret				Route #2		
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME								
Joseph Green		Mary Elizabeth Jenifer								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16b. SOCIAL SECURITY NO		17 INFORMANT		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
NO		214-58-4637		1525 Oates St. N.E., Wash., D.C.		PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Drowning</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____		6-17-69		
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY?				
						YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY Month, Day, Year		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)						
		6-19-69		Floating on bay & fell off						
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION (Street or R.F.D. No., City or Town, County, State)						
		Not known		Marshall Hall, Charles						
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>										
ACTUAL SIGNATURE		CHIEF MEDICAL EXAMINER		22b. DATE SIGNED						
EXAMINER'S NAME (Type)		M.D.		ASSISTANT MEDICAL EXAMINER		DEPUTY MEDICAL EXAMINER				
E. J. EDELEN										
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)				
Burial		7/2/1969		St. Joseph's Cemetery		Pomfret, Maryland				
24. FUNERAL DIRECTOR		ADDRESS		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE				
Arehart Funeral Home, Inc.		La Plata, Md.		JUL 3 1969		Charles Judge				



FOR STATE
HEALTH DEPT.

08300

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08293

1 DECEASED NAME (Type or Print) ALBERT		First Middle Last		2a DATE KNOWN OF EST. <input checked="" type="checkbox"/> Month Day Year 6-29-69		2b HOUR 5:00 P	
3 SEX male	4 RACE C	5 DATE OF BIRTH MAY 3, 1949	6 AGE (in years last birthday) 20 YRS.	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS HOURS MIN	2c DATE PRONOUNCED DEAD Month Day Year 7-4-69	2d HOUR 11:00
7a BIRTHPLACE (State or foreign country)		7b CITIZEN OF WHAT COUNTRY US		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH Charles	
10 CITY OR TOWN OF DEATH Waldorf Maryland		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b KIND OF BUSINESS OR INDUSTRY	
13a USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland		13b COUNTY Charles		13c CITY OR TOWN Waldorf		13d INSIDE CITY LIMITS? <input type="checkbox"/> YES <input type="checkbox"/> NO	
14 FATHER'S NAME First Middle Last Paul Joseph Lyles		15 MOTHER'S MAIDEN NAME First Middle Last LOUISA SHORTER					
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown)		16b SOCIAL SECURITY NO 212-54-3659		17 INFORMANT PAUL Lyles		ADDRESS Waldorf MD.	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))							
PART 1. DEATH WAS CAUSED BY:							
IMMEDIATE CAUSE (a) Straining							
DUE TO, OR AS A CONSEQUENCE OF							
(b) Strained floating							
DUE TO, OR AS A CONSEQUENCE OF							
(c)							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)							
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, item 1B) floating on log when they			
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21e PLACE OF INJURY (at home, farm, street, factory, office, building, etc.) Boat		21f LOCATION STREET, CITY OR TOWN, COUNTY, STATE Waldorf, Charles, Md.			
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE [Signature]		EXAMINER'S NAME (Type) M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		22b DATE SIGNED 7-5-69	
23a BURIAL CREMATION, REMOVAL (Specify)		23b DATE July 7, 1969		23c NAME OF CEMETERY OR CREMATORY John Wesley Met. Church		23d LOCATION (City or Town) (County) (State) Waldorf	
24 FUNERAL DIRECTOR Johnson Funeral Home Rt 224		ADDRESS		25a BY REGISTRATION 7-5-69		25b REGISTERED SIGNATURE [Signature]	

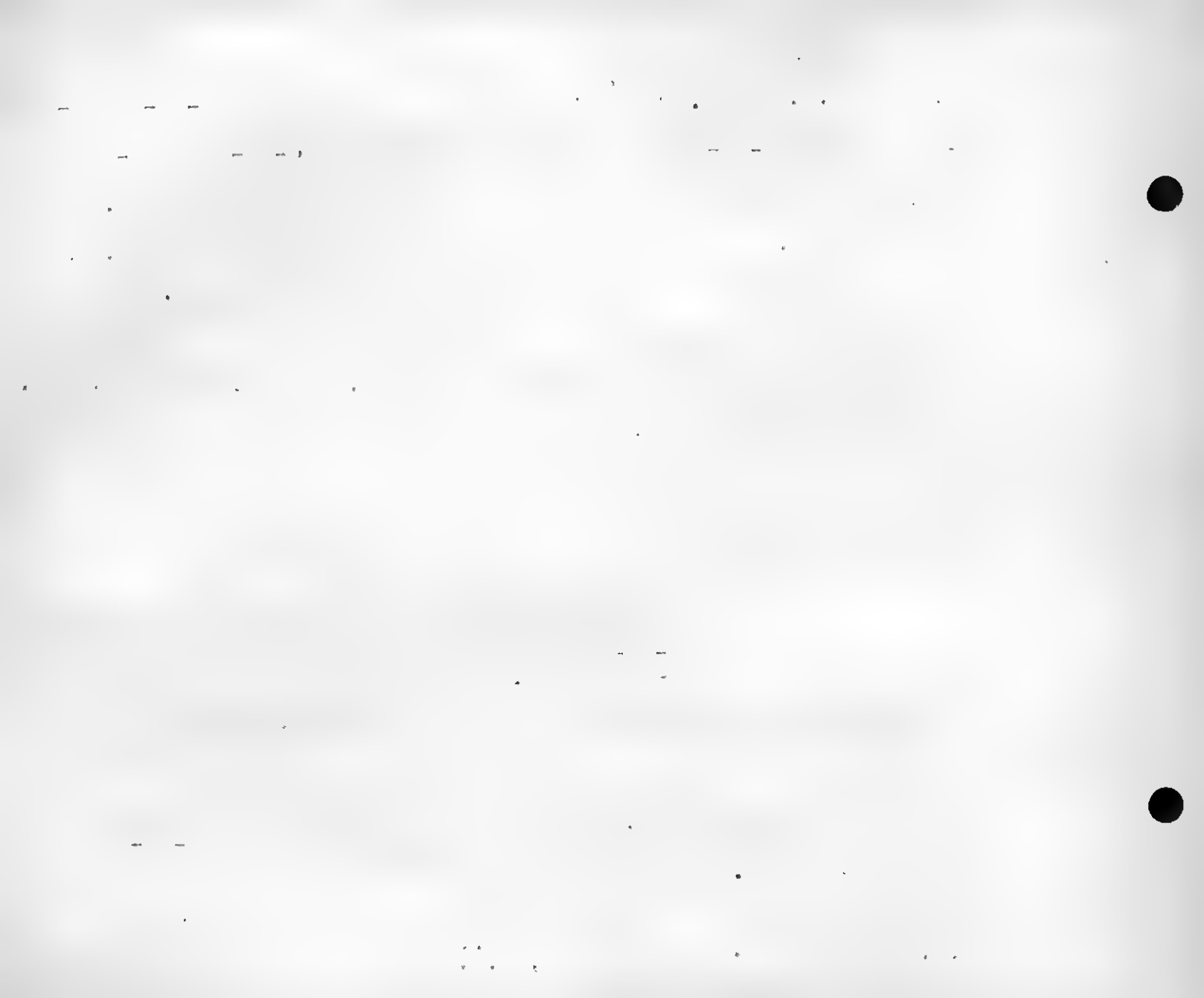
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MD. 21201
TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form 4MA. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form P-43. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										08294	
7/24/69 kk											
DECEASED NAME (Type or Print) Stanley E. Magness										2a. DATE KNOWN OF DEATH <input type="checkbox"/> Month <input type="checkbox"/> Day <input type="checkbox"/> Year <input type="checkbox"/> 2b. HOUR <input type="checkbox"/>	
S.G. Magnus, Army Civilian										6-27-69 11-45AM	
3. SEX Male		4. RACE White		5. DATE OF BIRTH 3-12-26		6. AGE (In years last birthday) 40 YRS		7. IF UNDER YEAR MONTHS DAYS		8. IF UNDER 24 HRS HOURS MIN	
7a. BIRTHPLACE (State or foreign country) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Charles County Md.		2c. DATE PRONOUNCED DEAD Month <input type="checkbox"/> Day <input type="checkbox"/> Year <input type="checkbox"/>		2d. HOUR <input type="checkbox"/>	
10. CITY OR TOWN OF DEATH Bryans Road Md.		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)				12a. USUAL OCCUPATION (Kind of work done during most of working life even if retired) US Army		12b. KIND OF BUSINESS OR INDUSTRY US Army			
13a. USUAL RESIDENCE (Where deceased lived, if institution - Residence before admission) STATE Alabama				13b. COUNTY Anniston		13c. CITY OR TOWN Anniston		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER Eulaton Rd.	
14. FATHER'S NAME First James A. Middle Magness Last Mitchell				15. MOTHER'S MAIDEN NAME First (Unknown) Middle Mitchell Last Mitchell							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes				16b. SOCIAL SECURITY NO. 217 24 6382		17. INFORMANT Dorothy W. Magness Anniston, Ala.				ADDRESS	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Injuries Multiple Extreme										Immediate	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 8411											
(b) Airplane Crash										Immediate	
(c) DUE TO, OR AS A CONSEQUENCE OF											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(c)											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>				21b. TIME OF INJURY 6-27-69 HOUR A.M. 10-30AM P.M.		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18) Airplane Crash					
21d. INJURY OCCURRED WHILE AT WORK <input checked="" type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No Anniston, Alabama		City or Town Anniston		County Charles		State Md.	
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE James E. Andrews MD				CHIEF MEDICAL EXAMINER <input type="checkbox"/>				22b. DATE SIGNED 6-27-69			
EXAMINER'S NAME (Type or Print)				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>							
				DEPUTY MEDICAL EXAMINER <input type="checkbox"/>							
				ADDRESS (Street, city, town, or county)							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 6-30-69		23c. NAME OF CEMETERY OR CREMATORY Anniston, Alabama		23d. LOCATION (City or Town) (County) (State)					
24. FUNERAL DIRECTOR W.W. Chambers Co.		1400 Chapin St., Washington, D.C.		NW REC'D BY REGISTRAR JUL 3 1969		25b. REGISTRAR'S SIGNATURE Charles Judge					



FOR STATE
HEALTH DEPT.

08302

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08295

1 DECEASED-NAME (Type or Print) Joseph First SILVERMAN Last			2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> Month 6 Day 5 Year 1969			2b. HOUR 1:45 M A													
3 SEX M		4. RACE W		5. DATE OF BIRTH 1-25-02		6. AGE (in years last birthday) 67 YRS		7. IF UNDER 1 YEAR MONTHS DAYS		7. IF UNDER 24 HRS HOURS MIN		2c. DATE PRONOUNCED DEAD Month 6 Day 5 Year 1969		2d. HOUR 1:45 M A					
7a. BIRTHPLACE (State or foreign country) N.Y.			7b. CITIZEN OF WHAT COUNTRY? USA			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH Charles County Md										
10. CITY OR TOWN OF DEATH La Plata				11. NAME OF HOSPITAL OR INSTITUTION (If not in hosp to give street address) ambulance en route to hosp				12a. USUAL OCCUPATION (Kind of work done during most of work life, even if retired) None				12b. KIND OF BUSINESS OR INDUSTRY None							
13a. USUAL RESIDENCE (Where deceased lived adm ssion) La Plata				13b. RESIDENCE BEFORE LAST ADM SSION La Plata				13c. CITY OR TOWN La Plata				13d. HOME CITY LIMITS? None				13e. STREET AND NUMBER 15610 NE 6 Ave			
14. FATHER'S NAME First Morris Middle Silverman Last Silverman						15. MOTHER'S M A D E N NAME First Franklin Middle Gandy Last Gandy													
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes no, if not known) No				16b. SOCIAL SECURITY NO 08709451				17. INFORMANT David Silverman				ADDRESS La Plata							
18. CAUSE OF DEATH (Enter any one cause per line for (a), (b), and (c)) PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Coronary Occlusion 6-5-69 4109 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH																			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																			
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?								20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19				21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)											
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc)				21f. LOCATION Street or R.F.D. No. City or Town County State											
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>																			
ACTUAL SIGNATURE E. J. EDELEN				M.D. CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>				DEPUTY MEDICAL EXAMINER <input type="checkbox"/>				22b. DATE SIGNED 6-5-69			
EXAMINER'S NAME (Type) E. J. EDELEN				ADDRESS (Street, city, town, or county)															
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial-Removal				23b. DATE 6/6/69				23c. NAME OF CEMETERY OR CREMATORY Lake Side Mem. Park				23d. LOCATION (City or Town) (County) (State) Miami, Fla.							
24. FUNERAL HOME AREHART FUNERAL HOME, INC. - La Plata, Md.																			
25. BY REGISTRAR JUN 9 1969																			
25b. REGISTRAR'S SIGNATURE [Signature]																			

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MD. 21201
TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form 4043. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1

08303

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

09782

1. DECEASED-NAME (Type or print)			First	Middle	Last	2a. DATE OF DEATH Month Day Year			2b. HOUR M		
James Edward Simmons (Kent)						June 27, 1969					
3. SEX Male		4. RACE Negro		5. DATE OF BIRTH June 27, 1969		6. AGE (In years last birthday) YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN	
7a. BIRTHPLACE (State or foreign country) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Charles		Md.			
10. CITY OR TOWN OF DEATH La Plata			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Physicians Memorial Hosp			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Infant			12b. KIND OF BUSINESS OR INDUSTRY --		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland			13b. COUNTY Charles		13c. CITY OR TOWN La Plata		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER --		
14. FATHER'S NAME First Middle Last Charles Edward Kent			15. MOTHER'S MAIDEN NAME First Middle Last Buelah Clara Simmons								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) no			16b. SOCIAL SECURITY NO. ---		17. INFORMANT Address Buelah C. Simmons-Mother-La Plata, Md.						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>777X Prematurity</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) <u>stoking the underlying cause last.</u> (b) <u></u> DUE TO, OR AS A CONSEQUENCE OF (c) <u></u>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 5 hrs.	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (1a)											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)			21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from <u>6/27</u> , 19 <u>69</u> , to <u>6/27</u> , 19 <u>69</u> , that (I) (we) last saw the deceased alive on <u>6/27</u> , 19 <u>69</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <u>Arturo M. Monteiro</u>			DEGREE ATTENDING PHYS. MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			22c. DATE SIGNED <u>6/29/69</u>					
22d. PHYSICIAN'S NAME (Type) <u>Arturo M. Monteiro</u>			22e. ADDRESS <u>La Plata, Md.</u>								
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			23b. DATE July 4, 1969		23c. NAME OF CEMETERY OR CREMATORY St. Joseph's Cemetery			23d. LOCATION (City or Town) (County) (State) Pomfret, Charles, Maryland			
24. FUNERAL DIRECTOR ADDRESS Arehart Funeral Home Inc., La Plata, Md.						25a. REC'D BY REGISTRAR DATE JUL 14 1969		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

June 27, 1968

James Earl Ray

Photo

June 27, 1968

London

London

Letter

Two letters received with

letter

clipped in letter

clipped

major area between

the two sides

not a direct hit

on

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

08304		DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201		08296	
MEDICAL EXAMINER'S CERTIFICATE OF DEATH					
1. DECEASED-NAME (Type or Print)		Michael Straus		20. DATE KNOWN OF DEATH	
M.C. Straus-Lt. USA				6-27-69 11:45 AM	
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (In years last birthday)	7. COUNTRY OF BIRTH	8. HOURS
Male	W.	3-2-44	25 YRS	USA	19
70. BIRTHPLACE (State or foreign country)		71. CITIZEN OF WHAT COUNTRY?		72. DATE PRONOUNCED DEAD	
Wisconsin		USA		6-27-69 11:45 AM	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)	
Bryans Road Md.				US Army	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN	
Fla.				St. Pete.	
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME		16. STREET AND NUMBER	
Clark W. Straus		Irene M. Ecker		4526 61st Lane North	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, go, or unknown)		16b. SOCIAL SECURITY NO.		17. INFORMANT	
Yes		349 36 4323		Clark W. Straus See 13 a c	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 1. DEATH WAS CAUSED BY:					
IMMEDIATE CAUSE (a) Injuries Multiple Extreme					Immediate
DUE TO, OR AS A CONSEQUENCE OF					
(b) Airplane Crash					Immediate
DUE TO, OR AS A CONSEQUENCE OF					
(c)					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY?	
				YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		21b. TIME OF INJURY Month Day Year		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)	
		10-30 AM 19		Airplane Crash	
21d. INJURY OCCURRED		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No. City or Town County State	
WHILE AT WORK <input checked="" type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				Bryans Road Md. Charles County	
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE		CHIEF MEDICAL EXAMINER		22b. DATE SIGNED	
EXAMINER'S NAME (Type)		ASSISTANT MEDICAL EXAMINER		6-27-69	
James E. Andrews MD		DEPUTY MEDICAL EXAMINER			
		ADDRESS (Street, city, town, or county)			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. NAME OF CEMETERY OR CREMATORY		23c. LOCATION (City or Town) (County) (State)	
Burial		Arlington Cemetery		Ft. Myer, Virginia	
24. FUNERAL DIRECTOR		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
W.W. Chambers Co.		JUL 2 1969		Charles Judge	

EPA

and

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• *Ch. 10: The End of the World* •